STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	010885	A. BUILDING: _____ B. WING _____	10/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND	2715 CHARLESTOWN PIKE JEFFERSONVILLE, IN 47130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. Survey Dates: October 6 and 7, 2014 Facility number: 010885 Provider number: 010885 AIM number: N/A Survey team: Gwen Pumphrey RN (TC) Gloria Reisert, MSW Jennifer Sartell, RN Trudy Lytle, RN Joshua Emily, RN Census bed type: Residential: 109 Total: 109 Census payor type: Medicaid: 45 Other: 64 Total: 109 Sample: 15 Riverbend was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality Review 10/08/14 by Lisa McColly	R 000		